

## ATTACHMENT 1

### **FY2020 ASSISTED LIVING PROVIDER PROVISION**

**A 1.1 PURPOSE:** The South Dakota Department of Human Services (DHS) Division of Long Term Services and Supports (LTSS) provides home and community-based service options to consumers 65 years of age and older and 18 years of age and older with disabilities. LTSS services enable these South Dakotans to live independent, meaningful lives while maintaining close family and community ties. LTSS provides home and community-based services sufficient in type, scope, amount, duration, and frequency, as specified in the LTSS Care Plan (see Provision B 2.2), to prevent or delay premature or inappropriate institutionalization.

LTSS consumers are given information on available home and community-based services and have the right to choose between receiving services in his/her home and community or receiving services in a nursing facility. When a consumer chooses an Assisted Living setting to receive services, a partnership between LTSS and the Assisted Living Provider is developed to ensure the health, safety, and welfare of the consumer.

**A 1.2 ADDENDUM:** In addition to the requirements outlined in the SD Medicaid Provider Agreement, the Provider agrees to the following:

**A 1.3 RULES AND REGULATIONS:** The Provider shall comply, for the duration of the agreement, with all Administrative Rules of South Dakota (ARSD) and South Dakota Codified Laws (SDCL) relative to the services provided. The Provider agrees to comply in full with all licensing requirements and other standards required by federal, state, county, city or tribal statute, regulation or ordinance in which the service and/or care is provided, for the duration of this agreement. Liability resulting from noncompliance with licensing and other standards required by federal, state, county, city or tribal statute, regulation or ordinance or through the Provider's failure to ensure the safety of all consumers served is assumed entirely by the Provider. Medicaid rules and regulations supersede all policy and procedures of the Assisted Living.

**A 1.4 VERIFICATION AND DOCUMENTATION:** The Provider is required to maintain documentation and verification demonstrating compliance with all provisions in this Assisted Living Provider Provision. Verification and documentation must be readily available upon request.

**A 1.5 REIMBURSEMENT:** The HOPE Waiver reimbursement rates are updated in July of each year. The Room and Board portion of the rate is adjusted in January of each year, based on the Cost of Living Adjustment (COLA). Notification of reimbursement rate adjustments is provided when these updates occur.

To be reimbursed at the established rate, the consumer must be physically present in the Assisted Living Center and must be receiving the assisted living service except in the following situations:

Hospital reserve bed days: An Assisted Living Center (ALC) may bill SD Medicaid for a maximum of five consecutive days when a recipient is admitted to an inpatient hospital stay. Up to five consecutive days may be billed to SD Medicaid per hospitalization; however, the recipient must return to the ALC for a minimum of 24 hours before additional hospital reserve bed days will be paid. When a consumer is transferred from an Assisted Living Center to a hospital, it is expected that the Provider will accept the consumer back at the Assisted Living Center at the time of hospital discharge.

Therapeutic leave days: An Assisted Living Center (ALC) may bill SD Medicaid for a maximum of five therapeutic leave days per month. Therapeutic leave days may be consecutive or non-consecutive. Therapeutic leave days are leave days from the Assisted Living Center for non-medical reasons (e.g., visits to the homes of family or friends).

The State's reimbursement for services rendered shall be considered payment in full. With the exception of the cost-share for waiver services, the Provider may not bill the consumer for any additional fees. The Provider will be made aware of the consumer's cost-share, if any, and will be responsible for collecting the cost-share from the consumer.

## **STANDARD PROGRAM DEFINITIONS**

**B 2.1** "Assisted Living Services" include personal care and supportive services that are furnished to eligible consumers who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services shall support full access to the greater community of consumers receiving Medicaid home and community-based services to the same degree of access as individuals not receiving Medicaid home and community-based services. The assisted living location promotes the health, treatment, comfort, safety, and well-being of residents, with easy accessibility for visitors and others. Services also include social and recreational programming, and medication assistance (to the extent permitted under state law). Services that are provided by third parties must be coordinated with the Assisted Living Provider and the LTSS Specialist.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24-hour skilled care. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

The following waiver services cannot be billed separately: homemaker; personal care, respite care, emergency response service, meals, environmental accessibility adaptations, and chore services.

Adult companion services, adult day services, nursing, nutritional supplements, specialized medical equipment, and specialized medical supplies may be authorized by the Long Term Services and Supports (LTSS) Specialist, based on assessed need as identified in the LTSS Care Plan with a threshold equal to the average cost of nursing home care. When these additional services are authorized by the LTSS Specialist, the services/supplies must be provided by a third party that is enrolled as a HOPE Waiver Medicaid provider.

**B 2.2 “LTSS Care Plan”** is a written person-centered plan developed by the Long Term Services and Supports (LTSS) Specialist with a consumer, as well as any people the consumer chooses, and must be finalized and agreed to, with the informed consent of the consumer in writing, and signed by all individuals and providers responsible for its implementation. The LTSS Care Plan (Attachment 2) reflects the services and supports that are important for the individual to meet the needs identified through an assessment of need, as well as what is important to the individual with regards to preferences for the delivery of such services and supports. If a consumer needs special supports or modifications based upon an assessed health and safety need, it must be identified within the LTSS Care Plan. Any modification of the federal regulations for the HCBS Settings Final Rule, as described at CFR 42 § 441.710(a)(1)(vi), must be individualized and addressed in the LTSS Care Plan. If a provider is implementing any modifications to any of these federal home and community-based settings requirements, the modification(s) must be discussed with the LTSS Specialist and documented in the LTSS Care Plan.

The Provider must notify the LTSS Specialist whenever a change in the Consumer occurs and/or a modification may be necessary. The Provider is expected to provide input and participate in the development of the initial and ongoing LTSS Care Plan.

**B 2.3 “Authorization for Services”** is the form sent to the Provider by LTSS which details the consumer’s contact information and the service authorized. The “Authorization for Services” form must be signed by the Provider and returned to LTSS within 7 business days of receipt. Failure to sign and return the “Authorization for Services” within the designated timeframe may negatively affect reimbursement.

**B 2.4 “Critical Service Need Consumer”**, is a consumer who needs a service provided on each assigned day or without the service (i.e., oxygen, injection, medication, wound care, therapy) the consumer’s health condition will immediately decline, or a consumer who has a health condition for which services should not be disrupted. The LTSS Specialist will communicate with the Provider (through the LTSS Care Plan) when a consumer has been identified as a Critical Service Need Consumer. When a Critical Service Need Consumer is identified, the LTSS Specialist is responsible to work with the consumer and the Provider to develop a back-up plan for service provision during

an emergency. The LTSS Specialist assists the consumer to identify any services that will be needed during an emergency.

The Provider must notify LTSS immediately of any change in scheduled visits or if unable to provide services to a Critical Need Consumer for any reason. The Provider is required to deliver specified services pursuant to the LTSS Care Plan, including required back-up plans.

**B 2.5** “Eligible Consumer” is any person in need of services who has been determined eligible by DHS. LTSS will provide on-going Case Management for each consumer. Case Management will include reassessing the consumer’s needs and eligibility at least annually, facilitating the development of the LTSS Care Plan, convening annual and as-needed person-centered planning meetings to develop and approve changes to the LTSS Care Plan, authorizing additional services by the Provider and/or third parties, and resolving any consumer concerns and other consumer-related issues.

**B 2.6** “Provider” refers to the person who is responsible for managing the Assisted Living Center and/or staff employed at the Assisted Living Center.

### **PROGRAM REQUIREMENTS**

**C 3.1** The Provider must conduct a background check to screen for abuse, neglect, and exploitation for all employees that provide direct services or supports. The Provider must develop a policy to implement State fingerprint background checks for all employees that provide direct services or supports. The policy must be readily available upon request. State fingerprint background checks for Assisted Living Centers will be a requirement starting in FY21. The provider may request the State’s approval for an alternative background check by completing and submitting a “Provider Request for Approval of Alternative Background Check”, along with a description of the alternative background check (produced by the company that process the background checks). To receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the state upon request and the description of the alternative background check must include verification that the following threshold criteria are met:

- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards)
- The alternative background check identifies the criminal history of the individual hired
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the provider

**C 3.2** The Office of the Inspector General (OIG) has the authority to exclude individuals and entities from federally funded health care programs and maintains a list of all currently excluded individuals. The Provider must check the OIG List of Excluded Individuals and Entities (LEIE) to ensure that new hires and current employees are not

on the excluded list at a minimum of once every six months. Search the OIG exclusions database online at <https://exclusions.oig.hhs.gov/>. The provider must have a policy that specifies the processes for conducting this verification.

**C 3.3** The Provider must report bed occupancy in the format and frequency required by Long Term Services and Supports.

**C 3.4** In accordance with South Dakota law, the Provider is mandated to immediately report any suspected abuse, neglect or exploitation of a Consumer. The Provider must have a policy for abuse, neglect or exploitation reporting which conforms to the mandatory reporting laws and must provide training on mandatory reporting laws to staff on an annual basis. See (SDCL 22.46) for South Dakota's laws regarding abuse, neglect or exploitation of elders or adults with disabilities.

**C 3.5** The Provider agrees to fully comply with the HCBS Settings Final Rule, 42 CFR §441.301(c)(4) and (5) specified here and in the HCBS Settings Guide to Expectations and Compliance. The Provider also agrees to cooperate with all action steps included in South Dakota's HCBS Settings Final Rule Transition Plan. Both documents are available online at <https://dss.sd.gov/medicaid/hcbs.aspx>.

**C 3.6** Facility standards and Provider policies must address the federal Medicaid requirements for Home and Community-Based Settings (HCBS Settings Final Rule) as specified in 42 CFR §441.301(c)(4) and (5). Specific policies that must be addressed as part of facility standards include the following:

1. Access to the broader community;
2. Privacy, dignity, respect, autonomy, choice, control, free from coercion and restraints, all resident's rights as noted in ARSD 44:70 and the HCBS Settings Guide to Expectations and Compliance;
3. Resident leases/tenant agreement requirements;
4. Roommate choice policy;
5. Visitor/Guest policy;
6. Policy to address ability to lock door to sleeping or living unit; and
7. Policy to address access to food.

**C 3.7** The Provider must have a written Quality Assurance and Improvement Plan detailing all activities conducted by the Provider to ensure quality service provision. The Provider must also have a Quality Assurance Policy specifying how the Provider will discover, fix, and report problems. The Provider will cooperate with quality performance site visit activities conducted by LTSS.

The Provider agrees to participate in any evaluation and/or consumer satisfaction program developed and/or conducted by the State which will be used to determine the effectiveness of service provision statewide.

**C 3.8** The Provider must have an Admission, Transfer and Discharge policy. When the Provider determines services to a consumer must be discontinued, the Provider must

notify the consumer in writing at least 30 days before the transfer or discharge, unless a change in the consumer's health requires immediate transfer or discharge or if the consumer has not resided in the Assisted Living Center for 30 days. The written notice must specify the reason for and effective date of the transfer or discharge and the new location to which the consumer will be transferred or discharged to; the conditions under which the consumer may refuse transfer within the Assisted Living; and a description of how the consumer may appeal a decision by the Assisted Living to transfer or discharge the consumer as per ARSD 44:70:09:14 Admission, Transfer, and Discharge Policies. Additionally, per ARSD 44:70:04:16 Discharge Planning, the Assisted Living Center shall initiate planning with applicable agencies to meet identified needs and consumers shall be offered assistance to obtain needed services upon discharge. Information necessary for coordination and continuity of care shall be made available to the setting and/or whomever the consumer is discharged to and to each referral agency as required by the discharge plan.

**C 3.9** The Provider must have a Grievance policy pursuant to ARSD 44:70:09:10. A consumer may voice grievances without discrimination or reprisal. A grievance may be in writing or oral and may relate to treatment furnished, treatment that has not been furnished, the behavior of other residents, and infringement of the resident's rights. The Assisted Living Center shall adopt a grievance process and make the process known to each resident and to the resident's immediate family. The grievance process shall include the facility's efforts to resolve the grievance and documentation of the grievance; the names of the persons involved; the disposition of the matter; and the date of disposition.

**C 3.10** The Provider must immediately notify LTSS of any consumer-related concerns, incidents and occurrences, including possible exploitation, that are not consistent with routine care. Providers must follow the Department of Health's policy for documenting the circumstances of any incident that involves restraint, seclusion, serious injury, missing person, or death from other than natural causes.

Upon being informed that an LTSS consumer has been hospitalized or discharged from the hospital, the Provider will immediately communicate this information to the LTSS Specialist to assure the consumer's need for service provision continue to be met appropriately.

**C 3.11** A copy of all policies must be readily accessible upon request.